MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

8756

CERTIFICATE OF DEATH

08763

Reg. Dist. No. 121

1. PLACE OF DEATH: COUNTY Howard MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highland Manor Rest Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3V01-4
STREET ADDRESS (If rural, give location) ? E. 24th Street

3. NAME OF DECEASED (Type or Print): (First) FLORA (Middle) (Last) BARNSTORF
4. DATE OF DEATH: (Month) Sept. (Day) 17, (Year) 1955

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed
8. DATE OF BIRTH: Nov. 30, 1881
9. AGE last birthday: 73 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Heinrich Blohm
14. MOTHER'S MAIDEN NAME: Johanna Diekmann

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: Mrs. Arthur Blohm 1609 E. North Ave. Baltimore 13 Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Vascular Accident (Cerebral Hemorrhage) 6 hours

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Arteriosclerosis, generalized
(c) Hypertensive CVD

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/1, 1955, to 9/17, 1955, that I last saw the deceased alive on 9/15, 1955, and that death occurred at 6 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Eug. J. Zuille M.D. ADDRESS: 5226 Baltimore National Bldg DATE SIGNED: 9/18/55

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation
DATE THEREOF: Sept. 20, 1955
NAME OF CEMETERY OR CREMATORY: Greenmount Crematory
LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REG.: 9-20-55
REGISTRAR'S SIGNATURE: [signature]
24. FUNERAL DIRECTOR: H. SANDER & SONS, INC. Baltimore, Maryland
ADDRESS: [signature]

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

8757

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08764

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH: COUNTY Howard MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City
LENGTH OF STAY (in this place) 34 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 77 New Cut Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Howard
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City
STREET ADDRESS (If rural give location) 77 New Cut Road

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) WASHINGTON (Last) BENTLEY

4. DATE OF DEATH: (Month) (Day) (Year) Sept. 29, 1955

5. SEX: Male

6. COLOR OR RACE: ~~White~~ C.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 7/1/1877

9. AGE last birthday 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Coal Yard

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John W. Bentley

14. MOTHER'S MAIDEN NAME: Mary Dorsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-07-6824

17. INFORMANT & ADDRESS: MRS VIOLA SMITH 75 NEW CUT RD. ELLICOTT CITY, MD

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A)	Cerebral Hemorrhage	Immediate
ANTECEDENT CAUSE (S) DUE TO (B)	—	—
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	Arteriosclerotic Cardio-Vascular Disease	1 year

422.1

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1954, to Sept 29, 1955, that I last saw the deceased alive on Sept. 23, 1955, and that death occurred at 2:15 P M, from the causes and on the date stated above.

SIGNATURE William H. Jessamy M. D. ADDRESS Ellicott City, Md. DATE SIGNED 9/29/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 10/2/55
NAME OF CEMETERY OR CREMATORY Hopkins Chapel
LOCATION (City, town, or county) (State) Highland Howard Co. Md.

DATE REC'D BY LOCAL REGISTRAR Oct. 1, 1955
REGISTRAR'S SIGNATURE John B. Longhran Per B.E.E.
24. FUNERAL DIRECTOR Easton Sons ADDRESS Ellicott City, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

08765

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

8758

CERTIFICATE OF DEATH

Reg. Dist. No. 194

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Howard — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fulton — LENGTH OF STAY (in this place) 5 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Simons Rest Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel
STREET ADDRESS (If rural, give location) Washington Boulevard

3. NAME OF DECEASED (Type or Print): (First) Frank (Middle) S. (Last) Collins
4. DATE OF DEATH: (Month) September (Day) 17 (Year) 1955
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: Sept 18, 1864
9. AGE last birthday: 90 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: US Govt
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Elijah Collins
14. MOTHER'S MAIDEN NAME: Martha Robinson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Mrs Vivian T. Coan, Laurel, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X

Immediate cause (a) cerebral hemorrhage — 6 hrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) cerebral arteriosclerosis — years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Jan, 1955, to 17 Sept, 1955, that I last saw the deceased alive on 16 Sept, 1955, and that death occurred at 3 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

John R Buell MD — 402 Main St. Laurel Maryland — 17 Sept 55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9/20/55	Snowhill Cemetery	Laurel, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR — ADDRESS
Sept 22, 1955	Mari G. Whitaker	Ike Wilt Donaldson, Laurel, Md

: 8759

08766
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 195

1. PLACE OF DEATH:
COUNTY Howard MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Laurel Rural
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Stockholm Resturant

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Prince George
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Laurel 16-41-2
STREET ADDRESS (If rural, give location) 200 10 th Street

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) LLOYD (Last) ELLINGER

4. DATE OF DEATH (Month) Sept. (Day) 16, (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: 1932

9. AGE last birthday: 23 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: ?

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.a

13. FATHER'S NAME: Harry Ellinger

14. MOTHER'S MAIDEN NAME: Nora Piner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) ?

16. SOCIAL SECURITY No.: 216-28-5127

17. INFORMANT & ADDRESS: Harry Ellinger, Gun Powder Rd. Laurel. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Gun shot wound in chest — Interval between Onset and Death: Instant

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Rwstaurant

21c. (City or town) Laurel rural (County) Howard (State) Md

21d. TIME OF INJURY (Month) (Day) 9-16-55 (Year) (Hour) 9.30P M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Gun shot wound in chest during altercation in resturant.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

SIGNATURE George E. Burdett
Ellicott City, Md.
M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 9-16-55

23. BURIAL, ~~CREMATION~~, REMOVAL (Specify): Burial

DATE THEREOF Sept 19 55

NAME OF CEMETERY OR CREMATORY Savage Cemetery

LOCATION (City, town, or county) (State) Savage-Howard Co. Md.

DATE RECD BY LOCAL REG 9/19/55

REGISTRAR'S SIGNATURE Frank Shipley

24. FUNERAL DIRECTOR Bartlett Donaldson

ADDRESS Laurel Md

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

8760

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08767

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY Howard MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ellicott City
LENGTH OF STAY (in this place) 12 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Highland Manor Court Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3 Vol-4
STREET ADDRESS (If rural give location) 2724 Reisterstown Road

3. NAME OF DECEASED: (Type or Print) (First) AGNES (Middle) - (Last) FOWBLE

4. DATE OF DEATH: (Month) Sept (Day) 14 (Year) 1955

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: Dec 15-1863

9. AGE last birthday 91 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret

10B. KIND OF BUSINESS OR INDUSTRY: Hsk.

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Wm. J Fowble

14. MOTHER'S MAIDEN NAME: Catherine Richards

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) N (If Yes, give war or dates of service) NW

16. SOCIAL SECURITY NO. ✓

17. INFORMANT & ADDRESS: Mrs Carrie Ensor - 4004 Groveland Rd Baltimore

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0
IMMEDIATE CAUSE (A) DUE TO Generalized Arteriosclerosis

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

APPROX. INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cachexia

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/2, 19 55 to 9/14, 19 55, that I last saw the deceased alive on 9/7, 19 55, and that death occurred at 6 P M, from the causes and on the date stated above.

SIGNATURE Wm J Twibly ADDRESS M. D. 5226 Balt. Nat'l Bk DATE SIGNED 9/15/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF Sept 17/55 | NAME OF CEMETERY OR CREMATORY Wesley | LOCATION (City, town, or county) Carroll Co (State) Md

DATE REC'D BY LOCAL REGISTRAR Sept. 19, 1955 | REGISTRAR'S SIGNATURE John Laughenour | 24. FUNERAL DIRECTOR Edw C Tipton, Hampstead Md | ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08768

CERTIFICATE OF DEATH

8761 Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Howard MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Highland Manor Nursing Home CHURCH RD - ELLICOTT CITY MD

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4
STREET ADDRESS (If rural give location) 5307 St. George Ave

3. NAME OF DECEASED: (Type or Print) (First) Katherine (Middle) (Last) Francis

4. DATE OF DEATH: (Month) SEPT. (Day) 18 (Year) 1955

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED
8. DATE OF BIRTH: 2/6/1877
9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Simon Otto
14. MOTHER'S MAIDEN NAME: Anna Koch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT & ADDRESS: J. LLOYD FRANCIS - 5306 KENILWORTH AVE

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause (a) Pneumonia, Lobar — Interval Between Onset And Death: 2 days
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Low Serum Proteins
DUE TO
(c) Diabetic Renal Disease (Kimmelstiel W. Is.) (260X) 490X

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus, Diabetic gangrene of area of legs

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1, 1955, to 9/18, 1955, that I last saw the deceased alive on 9/16, 1955, and that death occurred at 7 PM, from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Virgil Miller M.D. 5226 Balt. Nat. Pike 9/19/55

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
DATE THEREOF 9-20-55
NAME OF CEMETERY OR CREMATORY Loudon Park Cem.
LOCATION (City, town, or county) (State) Balto. MD.

DATE REC'D BY LOCAL REGISTRAR 9-22-55
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Henry H. Jenkins & Bro. ADDRESS 4905 York Rd.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

08769

8762

1963

Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH — COUNTY: Howard Co Md — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Florence — LENGTH OF STAY (in this place): all life
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY: Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Florence Md
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) HIRAM (Middle) C (Last) HAWKINS

4. DATE OF DEATH: (Month) Sept (Day) 30 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan 24 1895

9. AGE last birthday: 60 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Howard Co Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William B Hawkins

14. MOTHER'S MAIDEN NAME: Emma Clagett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): War I

16. SOCIAL SECURITY NO.: 218-14-0943

17. INFORMANT: Mary C. Hawkins. Elkridge, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 X

Immediate cause (a): Cardiac arrest, Cerebral hemorrhage — Interval between onset and death: 30 Sept 55 to 30 Sept 55

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): Arteriosclerosis, mild hypertension

(c):

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour):

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 30 Sept, 1955, to 30 Sept, 1955, that I last saw the deceased alive on 30 Sept, 1955, and that death occurred at 9:00 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Howard E Hall MD — ADDRESS: Elkridge, Md — DATE SIGNED: 1 Oct 55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct 3 1955 — NAME OF CEMETERY OR CREMATORY: Pine Hill Cem — LOCATION (City, town, or county) (State): Howard Co Md

DATE REC'D BY LOCAL REG.: Oct. 1, 1955 — REGISTRAR'S SIGNATURE: Courtney Gilbert, E. Pearle Mercier — FUNERAL DIRECTOR: Roy W Barber — ADDRESS: Ellicott City Md

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08770

8763

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH
COUNTY Howard MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 17 Merriman St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City
STREET ADDRESS (If rural, give location) 17 Merriman St.

3. NAME OF DECEASED (Type or Print) (First) GRAFTON (Middle) RAY (Last) HELM

4. DATE OF DEATH (Month) (Day) (Year) Sept 21, 1955

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Feb. 13, 1890

9. AGE last birthday 65 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk

10b. KIND OF BUSINESS OR INDUSTRY B & O R R

11. BIRTHPLACE (State or foreign country) Ellicott City, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James Helm

14. MOTHER'S MAIDEN NAME Lila Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. ?

17. INFORMANT AND ADDRESS Roberta Helm, Ellicott City, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 20 min

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) arteriosclerosis, generalized — 6-8 yrs
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 6

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1954, to Sept. 21, 1955, that I last saw the deceased alive on 11:30 PM, 1955, and that death occurred at 11:45 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Robert B Taylor MD — ADDRESS Ellicott City. Md — DATE SIGNED 9/22/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 9-24-55 — NAME OF CEMETERY OR CREMATORY Mt. View — LOCATION (City, town, or county) (State) Alpha, Md.

DATE REC'D BY LOCAL REG. Sept 23, 1955 — REGISTRAR'S SIGNATURE John B. Langhaus. Dep. B. E. L.

24. FUNERAL DIRECTOR — ADDRESS F.C. Higinbothom, Ellicott City, Md

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08771

8754

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH: COUNTY HOWARD MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Simpsonville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY HOWARD.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Simpsonville
STREET ADDRESS (If rural give location) Route 32 Md.

3. NAME OF DECEASED: (Type or Print) (First) MABLE (Middle) (Last) HOLLAND

4. DATE OF DEATH: (Month) (Day) (Year) Sept 29 1955

5. SEX: F

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) MARRIED

8. DATE OF BIRTH: SEPT 15, 1896

9. AGE last birthday 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: PERRY E JACKSON

14. MOTHER'S MAIDEN NAME: SARAH E JACKSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Mr. James Holland (Husband) Same as 2

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X

IMMEDIATE CAUSE (A) Mitral Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 6 mo-9 day

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Hypertensive Cardio Renal Desease — ?

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senility

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-24, 1955 to 9-29-, 1955 that I last saw the deceased alive on 9-29-, 1955, and that death occurred at 10. P M, from the causes and on the date stated above.

SIGNATURE M. D. C. F. Maloney ADDRESS 57 Winters Lane Catonsville 28 DATE SIGNED 9-29-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 10-3-55 — NAME OF CEMETERY OR CREMATORY Hopkins Chapel — LOCATION (City, town, or county) (State) Highland, Md.

DATE REC'D BY LOCAL REGISTRAR 10-3-55 — REGISTRAR'S SIGNATURE Marie G. Whitaker — 24. FUNERAL DIRECTOR Robert L. Snowden — ADDRESS Rockville, Md.

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

8765 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08772

CERTIFICATE OF DEATH

Reg. Dist. No. 195

Item 8, FilmG186 9-20-55 et

1. PLACE OF DEATH:
COUNTY Howard — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessup — LENGTH OF STAY (in this place) 15 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Blvd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessup
STREET ADDRESS (If rural give location) Washington Blvd

3. NAME OF DECEASED: (Type or Print) (First) Grover (Middle) Cleveland (Last) Kirk
4. DATE OF DEATH: (Month) Sept (Day) 9 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Oct. 14, 1888
9. AGE last birthday: 67 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Postmaster
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Post Office
11. BIRTHPLACE (State or foreign country): Catonsville Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Kirk
14. MOTHER'S MAIDEN NAME: Mary E. Bassler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Mrs. Dorothy Van Sweden, Hyattsville, Md. 6570-41st Ave

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause (a) Carcinoma Lung, left — Interval Between Onset And Death: 9 mos.
163X
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b)
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1 Jan. 55
19b. MAJOR FINDINGS OF OPERATION: Carcinoma, left lung
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1st, 1955 to Sept 8th, 1955, that I last saw the deceased alive on 9/8/55, 19..., and that death occurred at 12:30 A.M. from the causes and on the date stated above.
SIGNATURE (Degree or title) Frank Shipley -- See: Item 23
ADDRESS Savage, Md.
DATE SIGNED 9/9/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept 10 1955
NAME OF CEMETERY OR CREMATORY St Johns Cemetery
LOCATION (City, town, or county) Ellicott City Howard Co. (State) Md.
DATE REC'D BY LOCAL REGISTRAR 9/9/55
REGISTRAR'S SIGNATURE Frank Shipley,
24. FUNERAL DIRECTOR: Robert Donaldson
ADDRESS: Laurel, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

8766 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09832

CERTIFICATE OF DEATH

Reg. Dist. No. 191

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and le THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTE

1. NAME OF DECEASED (Type or Print): Joseph Mayer

2. DATE OF DEATH: 9/3/55

3. PLACE OF DEATH: A. ~~Baltimore City~~, Maryland, Howard County

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Manor Nursing Home

c. Length of stay in Baltimore: 90 Days 74 Yrs. Mos.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3V01.4

D. STREET ADDRESS (If rural, give location): 2048 E. Fayette St

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Widowed	2.	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Czechoslovakia

12. CITIZEN OF WHAT COUNTRY? ~~Yes~~

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hematemesis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Peptic Gastric Carcinoma

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY? YES ☐ NO ☐

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. I certify that (I) (this hospital) attended the deceased from Aug 28 1955 to Sept 3 1955, that (I) (we) last saw the deceased alive on Sept 1 1955, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Chas J Kirby M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

23B. ADDRESS: 5326 Balt Nat. Pike

23C. DATE SIGNED: 9/3/55

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE: OCT 5 1955

24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: OCT 10 1955

REGISTRAR'S SIGNATURE: John Longhurst

25. FUNERAL DIRECTOR ADDRESS: Huntington Williams

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

8787

08773

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH
COUNTY: Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Clarksville
LENGTH OF STAY (in this place): MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 00

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Clarksville
STREET ADDRESS (If rural, give location): X /

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Jacob	Winfield	Parlette	Sept.	3	1955

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	May 24, 1905	50 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm Owner	Farming	Maryland	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Winfield Scott Parlette	Annie S. Gambrill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	216-14-3991	Ruth Parlette, Clarksville, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: instant

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 7/26, 1946 to 9/3, 1955, that I last saw the deceased alive on 9/2/55, 19..., and that death occurred at 5:45 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Charles S. Whitaker	M.D.	Clarksville, Md.	9/5/55

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-6-55	Mt. Zion	Highland, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-5-55	Marie A. Whitaker	F.C. Higinbothom	Ellicott City, Md

8768

08774

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

Item 18 Film G160 9-22-55 ams

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 1926

1. PLACE OF DEATH:
COUNTY: HOWARD — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - West Friendship
LENGTH OF STAY (in this place): 15 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Howard
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Rural. West Friendship
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED: (Type or Print) (First) Alonzo (Middle) W. (Last) PENN

4. DATE OF DEATH: (Month) 9 (Day) 10 (Year) 19 55

5. SEX: W M

6. COLOR OR RACE: W M

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: 12-30-1885

9. AGE last birthday: 69 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Home Building

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Delanius Penn

14. MOTHER'S MAIDEN NAME: Isabelle Reckard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Miss Mary Belle Penn. West Friendship, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

4221

Immediate cause (a) Arteriosclerotic cardiovascular disease

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE: R. B. Fisher M. D.

CHIEF MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED: 9-10-55

23. BURIAL, CREMATION, REMOVAL. (Specify): Burial

DATE THEREOF: 9-13-55

NAME OF CEMETERY OR CREMATORY: Providence

LOCATION (City, town, or county) (State): Ellicott City, Howard Md.

DATE REC'D BY LOCAL REG.: Sept. 12, 1955

REGISTRAR'S SIGNATURE: Alice H. Hebb

24. FUNERAL DIRECTOR ADDRESS: Little & Haight - Sykesville, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

8769

08775

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

Item 11, Film 186 9-14-55 st

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 199

1. PLACE OF DEATH:

COUNTY Howard — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: X Ellicott City Rural

LENGTH OF STAY (In this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Route 40 6 miles west of Ellicott City

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Pa COUNTY

CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Pittsburgh 75 X - 3

STREET ADDRESS (If rural, give location): 4 Minnesota Ave.

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print)	4. DATE OF DEATH (Month) (Day) (Year)	5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE Last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Mln.
MICHAEL NORMAN PROHINSKY	Sept.6,1955 19	Male	White	Married	1902	53 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
C I O	Union	////////// Unknown // Pennsylvania	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Andrew Prohinsky	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	?	N.M.Prohinsky,5901 Sunset Ave. Balto. 7 Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

816X

Immediate cause (a) 3 rd degree burns entire body — DUE TO — Interval Between Onset and Death: Instant

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒
0		

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Highway	21c. (City or town) (County) (State)	
		Ellicott City (rural) Howard 13	Md

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
Sept.6,1955 5 P. M.		Head on Collision two cars-Deceased car burned.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE George L. Burgtorf M.D. Ellicott City, Md.

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ M. D.

DATE SIGNED Sept.6,1955

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	9-7-55	Pittsburgh,Pa	Pittsburgh, Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Sept 7, 1955	Alice M. Hebb	F.C.Higinbothem,Ellicott City,Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

8770

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08776

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Howard — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Ellicott City

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Highland Manor Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3 Vol-4

STREET ADDRESS (If rural, give location) 120 W. Lanvale St. ✓

3. NAME OF DECEASED: (Type or Print) (First) JENNIE (Middle) Bradley (Last) REILEY

4. DATE OF DEATH: (Month) Sept. (Day) 2, (Year) 19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 12-15-1857

9. AGE last birthday 97 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): W. Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James McKendree Reiley

14. MOTHER'S MAIDEN NAME: Margaret Stevenson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 9 (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Margaret C. Stevenson 2733 N. Charles

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

490X **Immediate cause** (a) Lobar Pneumonia — DUE TO — Interval Between Onset and Death: 2 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/15, 19 55, to 9/2, 19 55, that I last saw the deceased alive on 9/1, 19 55, and that death occurred at 7 A.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Chas J. Miller M.D. ADDRESS 5226 Baltimore Md. DATE SIGNED 9/2/55

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF Sept. 5, 1955

NAME OF CEMETERY OR CREMATORY Green Mount

LOCATION (City, town, or county) Baltimore, (State) Md.

DATE REC'D BY LOCAL REG. 9-2-55

REGISTRAR'S SIGNATURE Ida Hedrick

24. FUNERAL DIRECTOR John O. Mitchell & Sons ADDRESS 1900 Eutaw Pl.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8771

CERTIFICATE OF DEATH

08777

Reg. Dist. No. 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Howard — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Elkridge Rural — LENGTH OF STAY (in this place) 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 Box 104 Route 4 Rockburn Hill

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md — COUNTY Howard
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Elkridge Rural X
STREET ADDRESS R.#D 4 Box 104 Rockburn Hill (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Florence (Middle) M (Last) Sipes

4. DATE OF DEATH: (Month) Sept (Day) 19 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Feb 13 1881

9. AGE last birthday: 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Elkridge Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William McCauley

14. MOTHER'S MAIDEN NAME: Elva E. Ray

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) N — (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Donald J. Sipes 911 Desoto Rd Balto 29, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause — (a) 334X Coronary Occlusion — 15 min

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) Cerebral Hypertension — 3 yrs

DUE TO

(c) General arteriosclerosis — ?

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Left hemiplegia — July 1953

19a. DATE OF OPERATION: 0 — 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 7, 1953, to Sept 18 1953, that I last saw the deceased alive on Sept 18 1953, and that death occurred at 12 30, from the causes and on the date stated above.

SIGNATURE (Degree or title) Dr B B Brumbaugh — ADDRESS 36 Main St Elkridge Md — DATE SIGNED 9/19/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 9/22/53 — NAME OF CEMETERY OR CREMATORY London Park Cem. — LOCATION (City, town, or county) 3801 Frederick Rd (State)

DATE REC'D BY LOCAL REGISTRAR 9-20-53 — REGISTRAR'S SIGNATURE C.W. Pickard — 24. FUNERAL DIRECTOR John J. Cowan & Son — ADDRESS 2 Hollins

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

8772 — 08778 — Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Howard — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ellicott City. — LENGTH OF STAY (in this place) 8 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Shaffer's Conv. Retreat.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore. 3V01-4
STREET ADDRESS (If rural, give location) 3501 Seven Mile Lane.

3. NAME OF DECEASED (Type or Print): (First) Frederick (Middle) R. (Last) Smith.

4. DATE OF DEATH: (Month) September (Day) 8, (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed.

8. DATE OF BIRTH: June 13, 1875

9. AGE last birthday: 80 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist.

10b. KIND OF BUSINESS OR INDUSTRY: Die Making.

11. BIRTHPLACE (State or foreign country): Providence, R.I.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 180-09-4176

17. INFORMANT AND ADDRESS: Shaffer Conv. Retreat, Ellicott City, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1

Immediate cause (a) Coronary Occlusion — Minutes

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive C/V disease — 2 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0 — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 19 54, to Sept. 8, 19 55, that I last saw the deceased alive on Sept 7, 19 55, and that death occurred at 5:30 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Lee G. Rochman, MD — ADDRESS 1037 N. Calvert St — DATE SIGNED 9/8/55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Sept. 11, 1955 — NAME OF CEMETERY OR CREMATORY New Freedom Cemetery — LOCATION (City, town, or county) (State) New Freedom, York Co. Pa.

DATE REC'D BY LOCAL REG. Sept 9, 55 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR — ADDRESS Jacob Farlenstein, New Freedom, Pa.

8773

08779

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 194

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Howard MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Simpsonville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Howard
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Simpsonville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) IRVING (Middle) H (Last) VOLCKMAN

4. DATE OF DEATH (Month) Sept. 13 (Day) (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH: 5-4-1895

9. AGE last birthday: 60 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farm Owner

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles F. W. Volckman

14. MOTHER'S MAIDEN NAME: Minnie Priesterjohn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W W 1

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Charles W. Volckman, Simpsonville, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Strangulation by hanging — Interval between onset and death: instant

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY At home

21c. (City or town) Simpsonville (County) Howard (State) Md

21d. TIME (Month) (Day) (Year) (Hour) OF INJUR Sept. 13, 1955 7.30 PM

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE George E. Burgdorf
Ellicott City, Md.
M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 9-13-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 9-16-55

NAME OF CEMETERY OR CREMATORY: St. Paul

LOCATION (City, town, or county) (State): Fulton, Md

DATE REC'D BY LOCAL REG. Sept 15, 1955

REGISTRAR'S SIGNATURE Marie A. Whitaker

24. FUNERAL DIRECTOR ADDRESS: F. C. Higinbothom, Ellicott City, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08780

8774

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH:
COUNTY Howard MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge Rural
LENGTH OF STAY (in this place) 32 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 27 R.7.D.4 Lawyers Hill Rd

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Howard
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lawyers Hill Rd Elkridge (Rural)
STREET ADDRESS (If rural give location) Box 23 R.7.D.4

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Andrew (Last) Waltz

4. DATE OF DEATH: (Month) Sept (Day) 14 (Year) 1955

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married
8. DATE OF BIRTH: Feb 7 1877
9. AGE last birthday 78 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): accountant
10B. KIND OF BUSINESS OR INDUSTRY: B&O. R.R.
11. BIRTHPLACE (State or foreign country): Baltimore City
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Waltz
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 705-05-2507
17. INFORMANT & ADDRESS: Mrs Mamie Waltz Box 23, R.7.D.4 Elkridge Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE 410X	(A) Acute Dilatation of Heart	1 Hour
ANTECEDENT CAUSE (S)	DUE TO (B) Mitral Insufficiency & Chronic Myocarditis	9 yrs
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (C) General Arteriosclerosis Senility	6 Mos

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Shock from Minor Fall 9/8/55

19A. DATE OF OPERATION: 0
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1954 to Sept 14, 1955, that I last saw the deceased alive on 9/03/55, and that death occurred at 12½ P. M, from the causes and on the date stated above.
SIGNATURE Dr. B. Trumbauer M.D.
ADDRESS 3609 Main St Elkridge 27 Md
DATE SIGNED 9/14/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Sept. 17, 1955
NAME OF CEMETERY OR CREMATORY Lorraine Park
LOCATION (City, town, or county) (State) Baltimore Maryland

DATE REC'D BY LOCAL REGISTRAR Sept 16, 1955
REGISTRAR'S SIGNATURE A. A. Hedrick
24. FUNERAL DIRECTOR Joseph L. Ambrose
ADDRESS 1328 Lafayette Ave

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Sept. 17 1915